	INDIANA DEPARTMENT OF CHILD SERVICES **CHILD WELFARE POLICY**
	Chapter 4: Assessment **Section 31:** Child Fatality and Near Fatality Assessments
	Effective Date: February 1, 2022 — **Version:** 10

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POLICY OVERVIEW

When there is reason to believe that Child Abuse and/or Neglect (CA/N) may have been a factor in the fatality or near fatality of a child, the Indiana Department of Child Services (DCS) will complete an assessment. Assessments are also completed on reports of a child fatality or a near fatality when it is sudden, unexpected, and unexplained and the child is under three (3) years of age. The assessment is completed to identify and evaluate the circumstances surrounding the child fatality or near fatality, which will help to determine if CA/N was a factor. The safety and any potential risks for any other children in the home are also assessed.

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PROCEDURE

DCS will coordinate child fatality and/or near fatality assessments with a Law Enforcement Agency (LEA) and will coordinate and confer with the Coroner as necessary and appropriate. A DCS assessment shall not interfere with or duplicate the LEA investigation. The DCS local office shall complete an assessment that includes information obtained from the LEA or complete a joint DCS/LEA assessment. If DCS was not involved in a joint assessment, the information from the Law Enforcement Officer and the LEA report are resources for completion of the Assessment of Alleged Child Abuse or Neglect Report (311). For example, interview dates and birth dates may be found in LEA reports. If the information obtained from LEA is insufficient for DCS to make a determination of whether CA/N occurred, DCS will attempt to clarify any missing or insufficient information with the family. The findings of the DCS assessment may differ from the findings of the LEA assessment.

The DCS local office will confer and coordinate with the Institutional Child Protection Services (ICPS) Unit, as appropriate and needed, when it is determined a fatality or near fatality has occurred in an institutional setting.

The DCS Child Abuse Hotline (Hotline) and either the local child fatality review team or the statewide child fatality review committee will be notified by the Coroner of the death of a person who is less than 18 years of age, or appears to be less than 18 years of age, and who has died in a sudden, unexpected, or unexplained manner.

In the event of a child fatality and/or near fatality, if DCS has reason to believe a parent, guardian, or custodian was impaired, intoxicated, or under the influence of drugs or alcohol immediately before or at the time of death, DCS or LEA may request the parent, guardian, or custodian submit to an alcohol/drug screen. The request must be made within three (3) hours of

the near fatality or death of the child in order for a failure to screen to be considered as the equivalent of a positive screen for purposes of assessment (see policy 4.40 Drug Screening in Assessments). If DCS is unable to request a screen within the three (3) hour window and the parent, guardian, or custodian declines to screen, it may only be treated as a refusal, and not as the equivalent of a positive test, but the request should still be made and documented. DCS must document any noted or suspected impairment of the parent, guardian, or custodian observed at any time during the course of the assessment. If DCS is not on the scene of the fatality and/or near fatality, the Family Case Manager (FCM) should interview those professionals who were there (e.g., LEA and Emergency Medical Services [EMS]), and obtain any documentation regarding impairment or lack thereof, if applicable.

For **fatality** and **near fatality** assessments, the FCM will:

1. Initiate the assessment by seeing the child (in the case of near fatalities) (see policy 4.38 Assessment Initiation for further guidance);

   Note: If the child was deceased at the time of the initial report or the child died prior to contact by DCS, the FCM may create an "exception" for the initiation in the case management system that says "child was deceased prior to DCS making contact with child".

2. Complete a face-to-face interview with other children who live in the home or were present at the time of the fatality or near fatality to assess their safety and risks (see policy 4.09 Interviewing Children). Document any safety concerns, risks, and Child Advocacy Center (CAC) interviews (if applicable) in the safety section of the 311;
3. Assist LEA with conducting interviews of family members as requested;
4. Provide each parent, guardian, custodian, and alleged perpetrator with a copy of the Notice of Availability of Completed Report and Information and document in the 311 that the form was provided. If the alleged perpetrator is a child, provide the notice to the child's parent, guardian, or custodian. If the parent is a minor parent, provide the notice to both the minor parent and the minor parent's parent, guardian, or custodian;
5. Complete the Child Death Review;
6. Collect LEA records, hospital reports, Coroner's report, final autopsy report, and the state-issued Death Certificate so that a 311 may be prepared. Also, collect EMS records, local fire department records, Department of Natural Resources (DNR) reports, and the Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form, if applicable;

   Note: The Coroner's report, final autopsy report, and state-issued Death Certificate may take some time to obtain, depending on various circumstances. Once available, a copy of the Coroner's report and final autopsy report will be collected by the DCS local office. If the DCS local office is unable to obtain a state-issued Death Certificate, contact the Central Office Fatality Unit to request assistance in obtaining the document. Submission of the 311 to the Central Office Fatality Unit should not be delayed if only the state-issued Death Certificate is needed.

7. Ensure other actions are completed to conduct an appropriately thorough CA/N assessment in coordination with any LEA assessment (see policies 4.03 Conducting the Assessment and 4.04 Required Interviews);
8. Refer the family members to support services and document service referrals, if applicable (see policy 4.26 Determining Service Levels and Transitioning to Permanency Services);

9. Participate in consultation with a member of the Central Office Fatality Unit at approximately 45 days post-initiation of the assessment and determine if further consultation is needed;

   Note: This step is only for fatality assessments, and the Central Office Fatality Unit team member will contact the FCM. For near fatality assessments, the FCM may contact the Central Office Fatality Unit if assistance is needed.

10. Make an assessment finding (see policy 4.22 Making an Assessment Finding) and submit for approval to the FCM Supervisor.

    Note: For all fatalities and near fatalities, per IC 31-33-18-1.5(i) the 311 must include the following:
    a. A summary of the report of CA/N and a factual description of the contents of the report;
    b. The date of birth and gender of the child;
    c. The cause of the fatality or near fatality if the cause has been determined; and
    d. Whether DCS had any contact with the child or the perpetrator before the fatality or near fatality occurred. If DCS had contact, include the following information:
        i. The frequency of the contact or communication with the child or a member of the child's family or household before the fatality or near fatality and the date on which the last contact or communication occurred before the fatality or near fatality,
        ii. Any prior assessments and whether each assessment was substantiated or unsubstantiated, and
        iii. A summary of the child's most up-to-date case status at the time the fatality or near fatality assessment is closed, including:
            1. Whether the child's case was closed by DCS before the fatality or near fatality;
            2. Reasons the case was closed if closure occurred prior to the near fatality or fatality; and
            3. Date of case closure.

When a near fatality results in a fatality, the FCM must, as soon as possible but no later than 24 hours after learning of the fatality, complete the following:
1. Send an e-mail to a member of the Central Office Fatality Unit team to provide notification of the death; and
2. Update the allegations and add the fatality tag in the case management system.

<u>Procedure for Management for Assessments of Child Fatalities</u>
For Assessments of **Child Fatalities,** the FCM Supervisor will:
1. Engage with the FCM to discuss assessment details and offer guidance as needed;

   Note: IC 16-49-3-3 outlines the child fatality records that may be reviewed by the local child fatality review team.

2. Send one (1) hard copy of the assessment file to the Central Office Fatality Unit within 180 days following the Preliminary Report of Alleged Child Abuse or Neglect (310) date. Use the Child Fatality/Near Fatality Assessment Checklist to arrange the file. The assessment file should include:
   a. Completed and approved 310,

b. Substantiated and unsubstantiated history with DCS including 310s, 311s, and contact notes,
c. Completed and thoroughly documented assessment notes (add printed contacts from the case management system),
d. All drug screen results,
e. Copy of the Notice of Availability of Completed Reports and Information,
f. Completed but unapproved 311,
g. Hospital report,

Note: This refers to any relevant medical information relating to the fatality.

h. Emergency Medical Services (EMS), local Fire Department records, and/or Department of Natural Resources (DNR) reports, if applicable,
i. Copies of available newspaper clippings showing any information related to the assessment including, if applicable, criminal investigations, arrests, and trials,
j. LEA report, any information about charges filed, and/or arrests made,
k. Coroner and autopsy report, if applicable,

Note: If there was no autopsy, this needs to be documented in the narrative of the 311. There may be delays in obtaining Coroner reports and/or autopsy reports. For delayed receipt of the Coroner or autopsy reports, the FCM will document in the case management system the inability to obtain the report, and the FCM Supervisor will notify the Central Office Fatality Unit of the missing reports and the reason for delay. Upon receipt of the delayed report, the FCM Supervisor will complete and transmit the 311 as soon as reasonably possible.

l. State-issued Death Certificate, and

Note: A delay in obtaining the State issued Death Certificate is not a justification for delay in sending the assessment file to the Central Office Fatality Unit. The assessment file should be submitted to the Central Office Fatality Unit without the state-issued Death Certificate when the file is otherwise ready for submission. The DCS local office may request the Central Office Fatality Unit assist them in obtaining the state-issued Death Certificate.

m. Any and all other relevant documents or information.

3. Complete the 311;
4. Send the 311 (or request that it be sent) to the following persons, if substantiated, and follow-up by phone to confirm receipt:
   a. County Prosecutor,
   b. Investigating LEA, and
   c. County Coroner.

5. Assess to determine if a referral to the DCS Critical Incident Response Team (CIRT) is needed to assist local staff (see policy GA-17 Critical Incident Response).

For Assessments of **Child Fatalities,** the DCS LOD or DM (if applicable) will:

1. Assess to determine if a referral to the DCS CIRT is needed to assist local staff (see policy GA-17 Critical Incident Response);
2. Review the assessment file to ensure it includes all required documents; and

3. Ensure the Child Death Review is completed.

For Assessments of **Child Fatalities,** the RM will:

1. Assess to determine if a referral to the DCS CIRT is needed to assist local staff (see policy GA-17 Critical Incident Response); and
2. Review and sign the assessment file to verify it includes all required documents.

Procedure for Management for Assessments of Near Fatalities

For Assessments of **Near Fatalities**, the FCM Supervisor will:

1. Ensure the assessment is completed within 90 days and the case file contains:
   a. Completed and approved 310,
   b. Copies of any history the family may have had with DCS,
   c. Completed but unapproved 311,
   d. Completed and thoroughly documented assessment notes (add printed contacts from the case management system),
   e. Hospital report,

   Note: This refers to any relevant medical information relating to the near fatality.

   f. LEA report, any information about charges filed, and/or arrests made,
   g. Emergency Medical Services (EMS) or local Fire Department records, if applicable,
   h. Copies of available newspaper clippings showing any information related to the assessment including, if applicable, criminal investigations, arrests and trials.

2. Notify the Central Office Fatality Unit when the near fatality assessment is ready to be Approved;
3. Provide the Central Office Fatality Unit with detailed findings of substantiation or unsubstantiation on any alleged perpetrator;

   Note: The Central Office Fatality Unit will be tracking near fatalities, but will not be responsible for the review or approval of the assessments.

5. Notify the Central Office Fatality Team that the assessment is ready for approval in the case management system;
6. Ensure a copy of the completed 311 is sent to the following persons, if substantiated, and follow-up via phone to confirm receipt:
   a. County Prosecutor, and
   b. Investigating LEA.

7. Assess to determine if a referral to the DCS CIRT is needed to assist local staff (see policy GA-17 Critical Incident Response).

For Assessments of **Near Fatalities,** the DCS LOD or DM (if applicable) will:

1. Assess to determine if a referral to the DCS CIRT is needed to assist local staff (see policy GA-17 Critical Incident Response); and
2. Review the assessment file to ensure it includes all required documents.

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RELEVANT INFORMATION

Definitions

Coroner's Report

A Coroner's report is a document issued by an elected official (Coroner), usually based on the findings in an autopsy report.

Near Fatality

A near fatality is defined by Indiana Code as a severe childhood injury or condition that is certified by a physician as being life threatening. Life threatening is further defined as an injury or condition that is categorized as "serious" or "critical" in patient hospital records.

Sudden Unexplained Infant Death (SUID)

According to the Centers for Disease Control (CDC), sudden unexpected infant deaths are defined as infant deaths that occur suddenly and unexpectedly, and whose manner and cause of death are not immediately obvious prior to investigation.

Forms and Tools

- 4.B Tool: Assessment Narrative
- Assessment of Alleged Child Abuse or Neglect Report (SF 113) (311)
- Child Fatality/Near Fatality Assessment Checklist- available in hard copy
- Notice of Availability of Completed Report and Information (SF 48201)
- Preliminary Report of Alleged Child Abuse or Neglect (SF 114) (310)
- Sudden Unexplained Infant Death Investigation (SUIDI)- available in Apps at Work and at https://www.cdc.gov/sids/SUIDRF.htm

Related Policies

- GA-17 Critical Incident Response
- 4.03 Conducting the Assessment- Overview
- 4.04 Required Interviews
- 4.09 Interviewing Children
- 4.22 Making an Assessment Finding
- 4.26 Determining Service Levels and Transitioning to Permanency Services
- 4.38 Assessment Initiation
- 4.40 Drug Screening in Assessments

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LEGAL REFERENCES

- IC 16-49: Child Fatality Reviews
- IC 16-49-3-3: Review; records and information; not subject to subpoena or discovery or admissable as evidence
- IC 31-9-2-13: "Child"
- IC 31-33-8: Investigation of Reports of Suspected Child Abuse or Neglect
- IC 31-33-18-1.5: Written findings; copies to the department of child services; certain records held by governmental entities not confidential if redacted; procedure for redacting records
- IC 31-34-12-7: Failure to submit to drug or alcohol test

- IC 36-2-14-6.3: Coroner notification of child deaths; coroner consultation with child death pathologist; suspicious, unexpected, or unexplained child deaths; autopsy
- IC 36-2-14-18: Public inspection and copying of information; investigatory records; copies of autopsy; availability of report
- 42 USC Chapter 67 Child Abuse Prevention and Treatment and Adoption Reform

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PRACTICE GUIDANCE- DCS POLICY 4.31

Practice Guidance is designed to assist DCS staff with thoughtful and practical direction on how to effectively integrate tools and social work practice into daily case management in an effort to achieve positive family and child outcomes. Practice Guidance is separate from Policy.

Accidental Death

A Coroner's finding of "accidental death" does not preclude a DCS assessment finding of substantiated CA/N. For example, a Coroner may rule a child's drowning an "accidental death", but DCS may substantiate neglect due to the parent's lack of supervision of the child.

Autopsy Report

An autopsy report is a clinical report issued by a medical doctor/pathologist.

According to IC 36-2-14-18, a coroner shall make available, upon written request, a full copy of an autopsy report, including photographs, a video recording, or an audio recording of the autopsy to:

1. DCS, including the DCS local office where the death occurred;
2. The statewide child fatality review committee; and/or
3. The local child fatality review team where the death occurred.

> **Note:** One (1) and three (3) above are for purposes of conducting a review or an investigation of the circumstances surrounding the death of a child (as defined in IC 31-9-2-13(d)(1) and making a determination as to whether the death of the child was a result of abuse, abandonment, or neglect. **An autopsy report made available under this subsection is confidential and shall not be disclosed to another individual or agency, unless otherwise authorized or required by law.**

Documenting a Fatality or Near Fatality

If a child death occurs due to substantiated CA/N, the assessment worker must check the allegation of "death due to abuse" or "death due to neglect" in the findings section for Fatality or Near Fatality assessments in the case management system. The type of maltreatment which led to the death of the child must also be checked. A bathtub drowning, for example, might be marked "death due to neglect" (from the list of neglect maltreatment types) **and** "lack of supervision" or "environment life/health endangering," depending upon the circumstances.

Near Fatality

Once the criteria for near fatality is met (see Definitions above), the allegation of "near fatality" should be marked along with any other type of maltreatment if the allegations are substantiated.

> **Note:** Near fatality and fatality cannot be designated for the same originating injury. If a child dies as a result of the near fatality injury, the assessment is to be considered as a fatality only. The FCM Supervisor should add a mandated reason of fatality in the case management system.

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